DSS-AA-625E-04/00

INTAKE ASSESSMENT

Client Name: _____

Address:

_____

_____

Phone: _____

DOB: _____ **Age** _____

CID NUMBER: _____

Today's Date: _____

Intake Worker: _____

Person Calling: _____

Phone: _____

Relationship: _____

TYPE OF REFERRAL/REQUEST:
(Check all that apply)

- ☐ **Protection**
  - ☐ Priority 1
  - ☐ Priority 2
- ☐ Ombudsman
- ☐ Assessment
- ☐ PAA
  - ☐ at home
  - ☐ in nursing home
  - ☐ in hospital
  - ☐ Other
- ☐ Brief Services
- ☐ In-Home Services
- ☐ Placement
- ☐ Respite Care
- ☐ TXIX Transportation
- ☐ Senior Companion
- ☐ Other

IS THE CLIENT: (check all that apply)

- ☐ Physically Disabled (under 60)
- ☐ Mentally ill
- ☐ MR/DD
- ☐ Elderly
- ☐ Other

INCOME:

$ _____ Per _____

RESOURCES:

$ _____

WORKER ASSIGNED: _____

DATE: _____

SUPERVISOR: _____

OTHERS INVOLVED: (Support System)

☐ Spouse, Name:

_____

_____

☐ Family Member(s), Name(s):

_____

_____

_____

_____

☐ Other Agency(s)

_____

_____

_____

_____

Is the person calling formally requesting a specific ASA service? ☐ Yes ☐ No

If Yes, proceed with program procedures.
If No, no further involvement is required.

What is the nature of the problem:

(explain in as much detail as needed, use back if necessary)

_____

_____

_____

_____